Texas Department of Insurance
Division of Workers' Compensation
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645
512-804-4000 telephone • 512-804-4811 fax • www.tdi.texas.gov

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name and Address

TEXAS HEALTH FORT WORTH
3255 WEST PIONEER PARKWAY
PANTEGO TEXAS 76013

DWC Claim #:
Injured Employee:
Date of Injury:
Employer Name:
Insurance Carrier #:

Respondent Name
HARTFORD CASUALTY INSURANCE CO

Carrier's Austin Representative Box
Box Number 47

MFDR Tracking Number
M4-12-0929-01

MFDR Date Received
November 21, 2011

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "...per ASC RULE 134:402: Outpatient Hospital Rule 134.03 [sic], HCPS's are payable at 200% of the correct fee schedule allowable. We submitted an appeal to the carrier but they have chosen to deny all of our requests, saying 'the type of bill code is not valid PPS type of bill.' This bill type is 134.1 = hospital, 3 = outpatient 4= last or interim claim. Being this is the last claim for this patient's therapy, this bill type is correct."

Amount in Dispute: $222.50

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "Rule 134.403 (b) (3) + Rule 134.402 (d) please see attached supporting documentation."

Response Submitted by: The Hartford

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
May 4, 2011 and May 6, 2011	Outpatient physical therapy, CPT codes 97035 x 2 and 97110 x 4	$222.50	$222.50

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §134.403, titled *Hospital Facility Fee Guideline – Outpatient*, effective for medical services provided in an outpatient acute care hospital on or after March 1, 2008, set out the reimbursement guidelines for hospital outpatient services.

3. 28 Texas Administrative Code §134.203, sets out the fee guidelines for professional medical services provided on or after March 1, 2008.
4. The services in dispute were reduced/denied by the respondent with the following reason codes:

   Explanation of benefits dated August 5, 2011 and October 31, 2011
   - 125 – Payment adjusted due to a submission/billing error(s). The type of bill code is not a valid PPS type of bill.

Issues

1. Did the requestor perform physical therapy/occupational therapy in a facility setting?
2. Is the requestor entitled to reimbursement?

Findings

1. This dispute pertains to physical therapy/occupational therapy provided to the injured employee performed in a facility setting. The requestor has listed May 4, 2011 through May 6, 2011 as the dates of service in dispute.
2. Division rule at 28 TAC §134.403(h) states, in pertinent part, that "for medical services provided in an outpatient acute care hospital, but not addressed in the Medicare payment policies as outlined in subsections (f) (1) or (f) (2) of this section, and for which Medicare reimburses using other Medicare fee schedules, reimbursement shall be made using the applicable Division Fee Guideline in effect for that service on the date the service was provided."
   - The disputed charges are therefore, subject to the provisions of 28 Texas Administrative Code §134.203.
3. 28 Texas Administrative Code §134.203 states in pertinent part, "(b) For coding, billing, reporting, and reimbursement of professional medical services, Texas workers' compensation system participants shall apply the following: (1) Medicare payment policies, including its coding; billing; correct coding initiatives (CCI) edits; modifiers; bonus payments for health professional shortage areas (HPSAs) and physician scarcity areas (PSAs); and other payment policies in effect on the date a service is provided with any additions or exceptions in the rules."
   - The requestor billed CPT codes 97010, 97110 x 2 units and 97035 on May 4, 2011 and May 6, 2011.
   - The requestor seeks reimbursement for CPT codes 97110 x 2 units and 97035.
4. 28 Texas Administrative Code §133.307 states in pertinent part, "(c) Requests. Requests for MFDR shall be filed in the form and manner prescribed by the division. Requestors shall file two legible copies of the request with the division... (2) Health Care Provider or Pharmacy Processing Agent Request. The requestor shall provide the following information and records with the request for MFDR in the form and manner prescribed by the division. The provider shall file the request with the MFDR Section by any mail service or personal delivery. The request shall include: (M) a copy of all applicable medical records related to the dates of service in dispute."
   - The requestor submitted documentation to support the billing of CPT code 97110 x 2 units and 97035 rendered on May 4, 2011 and May 6, 2011.
5. 28 Texas Administrative Code §134.203 states in pertinent part, "(c) To determine the MAR for professional services, system participants shall apply the Medicare payment policies with minimal modifications. (1) For service categories of Evaluation & Management, General Medicine, Physical Medicine and Rehabilitation, Radiology, Pathology, Anesthesia, and Surgery when performed in an office setting, the established conversion factor to be applied is $52.83. For Surgery when performed in a facility setting, the established conversion factor to be applied is $66.32. (2) The conversion factors listed in paragraph (1) of this subsection shall be the conversion factors for calendar year 2008. Subsequent year's conversion factors shall be determined by applying the annual percentage adjustment of the Medicare Economic Index (MEI) to the previous year's conversion factors, and shall be effective January 1st of the new calendar year..."
   - The Medicare reimbursement amount for CPT code 97110/unit is $11.80. With the division established conversion factor the fee guideline reimbursement amount is $18.94/unit x 2 units = $37.88. The requestor seeks reimbursement in the amount of $37.42; this amount is recommended for dates of service May 4, 2011 and May 6, 2011.
   - The Medicare reimbursement amount for CPT code 97035/unit is $29.30. With the division established conversion factor the fee guideline reimbursement amount is $47.03 x 4 units = $188.12. The requestor seeks reimbursement in the amount of $185.08; this amount is recommended for dates of service May 4, 2011 and May 6, 2011.
   - Reimbursement is recommended in the amount of $222.50.

Conclusion

For the reasons stated above, the Division finds that the requestor has established that additional reimbursement is due. As a result, the amount ordered is $222.50.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code Sections 413.031 and 413.019 (if applicable), the Division has determined that the requestor is entitled to additional reimbursement for the services involved in this dispute. The Division hereby ORDERS the respondent to remit to the requestor the amount of $222.50 plus applicable accrued interest per 28 Texas Administrative Code §134.130, due within 30 days of receipt of this Order.

Authorized Signature

		June 7, 2013
Signature	Medical Fee Dispute Resolution Officer	Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute may appeal this decision by requesting a contested case hearing. A completed **Request for a Medical Contested Case Hearing** (form **DWC045A**) must be received by the DWC Chief Clerk of Proceedings within **twenty** days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. The party seeking review of the MDR decision shall deliver a copy of the request for a hearing to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §148.3(c), including a **certificate of service demonstrating that the request has been sent to the other party**.

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.